Post-Deployment Management of Combat-Related Distress Reactions and Disorders

David M. Benedek, M.D.
LTC, MC, USA
Assoc. Prof/Asst. Chair
Dept. of Psychiatry
Uniformed Services University School of Medicine

dbendek@usuhs.mil
301-319-4944

Disclaimer

Ideas and opinions expressed herein are those of presenter and do not necessarily reflect those of the U.S. Army Medical Corps, the U.S. Army, the DoD, or other branches of the U.S. Government

Uniformed Services University of the Health Sciences

Your Nation's Federal Medical School

Objectives

- Overview of “Differential Diagnosis” in the aftermath of Traumatic Exposure
- Comments on Intervention
  - Recovery environment
  - Psychosocial and Pharmacological Therapy
- Case Vignette

Resources

- www.usuhs.mil/CSTS
- Iraq War Clinician Guide, 2nd Edition; www.ncptsd.va.gov/war/guide
- Benedek DB and Ursano RJ, "Military and Disaster Psychiatry," in Saddock BJ and Saddock VA, eds, Kaplan & Saddock's Comprehensive Textbook of Psychiatry, 8th ed., Lippincott, Williams, & Wilkins, 2005.

Traumatic Stress Response

- Phase I--Immediate Response
  - strong emotions, disbelief, numbness, fear, confusion
  - Signs/Symptoms of Anxiety and Autonomic Arousal are a predictable response
  - Result of release of stress hormones/catecholamines

Traumatic Stress Response

- Phase II--Delayed Response (after one week)
  - Intrusive Recollections
  - Persistent autonomic arousal (startle, hypervigilance, insomnia, nightmares)
  - Multiple Somatic Symptoms (dizziness, headache, fatigue, nausea)
  - Anger/Irritability, Grief/Mourning, Apathy/Withdrawal

Traumatic Stress Response

- Phase III--Chronic (months to years)
  - disappointment/resentment
  - continued intrusive/arousal symptoms for some
  - persistent sadness/resentment for others
  - avoidance of triggers/reminders
  - Re-focus on new challenges/rebuilding of lives for majority

Differential Diagnosis: Phase II

- Continued Autonomic Symptoms
  - PTSD
  - Substance Abuse
  - Somatization Disorder
- Persistent Anger/Irritability/Depression
  - Major Depressive Disorder, Other Depressive Dx
- Bereavement/Complicated Grief

Differential Diagnosis: Phase III

- Autonomic Symptoms
  - PTSD
  - secondary effects of exposure chem/bio?
- Mood Disturbance
  - Recurrent Major Depression
  - Dysthymic Disorder
  - Substance Abuse/Dependence

Diagnostic Distinctions

- With anxiety, duration, degree of impairment clarify “normal” v. acute stress disorder v. PTSD
- With mood duration, degree, and identified loss clarify MDD v. Dysthymic Disorder v.Grief Reaction
- Caveat: “Distress” need not have fit into a DSM-IV diagnostic category

Treatment Considerations

- Pre-morbid history (function/presence of mental disorder) important considerations for treatment/prognosis
- History (personality/substance use) equally important in ruling in/out or predicting potential contributions of alcohol/drugs to observed symptoms (somatic, mood, or anxiety)

Other Factors in Assessment

Stressors Not Directly Related To Combat

Recovery Environment

Comorbidity and/or Sub-threshold symptoms

Summary

- Individuals may present with a variety of symptoms/syndromes across a timeline after combat exposure; PTSD is one consideration
- Initial symptoms may reflect physical injury/exposure, do not necessarily predict long-term morbidity (even if symptoms are severe)
- Information/risk communication and triage are initial considerations

Summary (cont.)

- Beyond direct exposure:
  - Anxiety Disorders (PTSD)
  - Mood Disorders
  - Somatization Disorders
  - Substance Use Disorders
  - Grief Reactions
  - Distress
- Duration/degree of impairment clarify diagnosis/prognosis and direct treatment

Management Considerations

Importance of the Recovery Environment

Treatment of Specific Disorders

Intervention beyond treatment of Disorder

Range of Mental Health in Disaster

- Change in Safety
- Sleep Disturbance
- Change in Travel

- Resilience
- PTSD
- ASD
- Depression

- Evacuation
- Smoking
- Alcohol
- Over dedication

Female US Reserve E-6

- Short of breath, unable to pump gas
- Re-deployed due to reactive airway disease in theater
- No significant battle exposures
- Only woman in Gulf fuel supply unit
- Tent set on fire with her inside
- Rescued, but no significant action taken

Symptoms and problems

- Poor sleep/nightmares
- “Not as helpful” at her civilian workplace
- Feels isolated
- Angry at self for increased tobacco use even--she knows its not good for asthma; inhalers make her more nervous . . .
- Limited contact with her parents; spouse says “We’re both lucky you are home & safe.”

Enhancing the Recovery Environment

Recovery Is promoted by:

- **Finding benefit**
- **Sense of relationship with the divine**
- **Trauma exposure-type treatment**
- **Other forms of treatment (supportive, stress inoculation, CBT, etc)**
- **Disclosure / Social support**
- **Perception that the social milieu accepts one's reactions and welcomes disclosure**
- **Seeing ourselves as heroes/survivors**
- **Positive emotions**

» **Watson, P. NCPTSD, 2005**

Treatment of Disorders

- Psychotherapy
  - CBT and Exposure-based therapies
  - EMDR
- Pharmacotherapy
  - SSRIs
  - Other medications
- Evidence Basis
- Practice Guidelines (APA, VA/DoD)

APA Practice Guidelines: Initial Assessment

- Comprehensive assessment should only be made in a safe environment, usually several days to weeks following the event.
- More acutely, supportive measures to provide information, relieve anxiety, ensure safety, and attend to physical problems and routine needs are appropriate.
- There is no evidence supporting the use of wide scale individual or group debriefing techniques for the prevention of PTSD.

Specific Information for Military

- Reason for joining
- Nature of duties and length of service
- Disciplinary actions and awards
- Frequency and effects of separation from family
- Location of events, seeing atrocities, death or injury of children or friends
- Sense of guilt with regard to actions or inaction

Selection of Treatments

- What does the patient see as primary problem(s), what settings, and which are most troubling
- What are the short and long term goals
  - Reduction in symptoms
  - Adaptive coping
  - Reduce restrictions of daily living / risk behaviors
  - Enhance decision making skills
  - Improve interpersonal relationships
  - Examine personal beliefs, expectations, constructs re: future, risks of life, and sense of safety

Management of Co-morbid Disorders

- Mood and anxiety disorders and substance misuse contribute to the severity of symptoms and course of the disorder
- Treatment of co-morbid disorders should be initiated in parallel with treatment of PTSD

Psychopharmacologic Treatment

- SSRIs are first line pharmacologic treatment:
  - Ameliorate all three symptom clusters
  - Effective for co-morbid disorders (mood and anxiety – possibly substance use)
  - May reduce irritability and aggressive behaviors that complicate management
  - Relatively few side effects
  - Only medications shown to benefit in well designed prospective trials

Adjunctive Treatments

- Second generation antipsychotic medications may have a role if there is evidence of misperception or paranoia and in low dose for sleep or agitation
- Benzodiazepines should be avoided (or at least considered carefully) because they may interfere with cognitive processing
- Beta blockers and alpha agonists may play some role
- Recently published studies of prazocin support its use; this appears particularly effective in reducing intrusive symptoms (nightmares).**

Psychotherapy for PTSD

- Cognitive Behavior Therapy (CBT):
  - Corrects irrational beliefs & thoughts
  - Promotes rational behavioral changes
- Other Exposure-based therapies:
  - Helps confront stimuli associated with trauma
  - Identifies & neutralizes behavioral cues
  - Virtual reality may provide most effective exposure mechanism
    - Appears useful in Vietnam vets and WTC survivors

though not yet proven in controlled studies